Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-10-2941-01

MFDR Date Received
February 26, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…because Provider did not request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section §134.403(f)(1)(A). Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

Amount in Dispute: $9,825.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "a labral repair (CPT 29807) is documented and was also billed by the surgeon, . . . Vista Hospital of Dallas billed CPT 29806 59 (capsulorrhaphy) and this procedure was denied as documentation does not support the level of service billed. The 59 modifier is not supported as this Is not the procedure documented as performed. . . . as a labral repair was also performed; it is incorrect coding to also code the debridement as a more extensive procedure was performed. . . . as an open biceps tenodesis was documented as performed; it is incorrect coding to also code the debridement as a more extensive procedure was performed. . . . Vista Hospital billed for an extensive debridement (CPT 29823 59) which was denied as documentation does not support the level of service billed. The 59 modifier was not supported as more extensive procedures were performed in all areas of the shoulder of which the debridement was incidental except for the debridement of the supraspinatus. . . . Vista Hospital has billed unlisted code CPT 20999 (Unlisted procedure, musculoskeletal system, general) or CPT 29999 (Unlisted procedure, arthroscopy) . . . an open biceps repair was performed. There is an appropriate code for this procedure which was not billed by the Vista Hospital. An unlisted code should not be billed when there is an appropriate code. . . . a bursectomy was documented as performed, however this is included in the definition of CPT 29826 and is not separately payable and should not be unbundled. . . . It is not clear if the unlisted code CPT 20999 or 29999 was billed for this procedure. . . . Liberty Mutual believes that Vista Hospital of Dallas has been appropriately reimbursed for services rendered."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2009	Outpatient Hospital Services	$9,825.33	$4,613.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - X815 – THIS PROCEDURE IS INCIDENTAL TO THE PRIMARY PROCEDURE, AND DOES NOT WARRANT SEPARATE REIMBURSEMENT. (X815)
   - B207 – THIS IS AN UNLISTED PROCEDURE. PLEASE RESUBMIT WITH A MORE DESCRIPTIVE CODE. (B207)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 87070 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for

Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.57. 125% of this amount is $15.71

- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.46. 125% of this amount is $4.33
- Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.46. 125% of this amount is $4.33
- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,914.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,215.22. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.246. This ratio multiplied by the billed charge of $1,669.60 yields a cost of $410.72. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,215.22 divided by the sum of all APC payments is 66.67%. The sum of all packaged costs is $9,026.34. The allocated portion of packaged costs is $6,017.56. This amount added to the service cost yields a total cost of $6,428.28. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $801.64. 50% of this amount is $400.82. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $3,616.04. This amount multiplied by 200% yields a MAR of $7,232.08.
- The insurance carrier denied procedure code 29823-59 with reason code X901 – "DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED." CPT code 29823 is defined as "Arthroscopy, shoulder, surgical; debridement, extensive." Review of the submitted documentation finds debridement performed in multiple areas including the supraspinatus, biceps tendon, and further including chondroplasty of the glenoid. Extensive debridement is documented. The level of service billed is supported. The respondent's position statement argues that "the operative report documents debridement of the biceps tendon, however as an open biceps tenodesis was documented as performed; it is incorrect coding to also code the debridement as a more extensive procedure was performed. However, there was a documented debridement of the supraspinatus tendon and no more extensive procedure performed on this body part. As such, it would have been appropriate to bill for a limited debridement (CPT 29822 59) . . . Vista Hospital billed for an extensive debridement (CPT 29823 59) which was denied as documentation does not support this level of service." While the documentation does support that an open biceps tenodesis was performed, it was not billed for. Medicare correct coding edits only apply to reported codes. As the tenodesis procedure was not coded on the bill, there is no conflict and no CCI edit to apply. Moreover, this argument, along with several new explanations, denial reasons and defenses asserted in the respondent's position statement, was not previously found in the documentation that had been presented to the requestor prior to the filing of this medical fee dispute. Per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was submitted to support that these denial reasons were ever presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Therefore, any newly raised defenses or denial reasons shall not be considered. Only the above-enumerated reason codes will be considered in this review. The insurance carrier's denial reason is not supported; therefore these services are reviewed for payment according to applicable fee guidelines. Procedure code 29823 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are

classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,914.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,215.22. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.246. This ratio multiplied by the billed charge of $1,669.60 yields a cost of $410.72. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,607.61 divided by the sum of all APC payments is 33.33%. The sum of all packaged costs is $9,026.34. The allocated portion of packaged costs is $3,008.78. This amount added to the service cost yields a total cost of $3,419.50. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $606.18. 50% of this amount is $303.09. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $1,910.70. This amount multiplied by 200% yields a MAR of $3,821.40.

- Procedure code 29806-59 cannot be recommended for reimbursement. Review of the submitted medical documentation finds that this procedure code is not supported as billed.
- Procedure code 29999 cannot be recommended for reimbursement. Review of the submitted medical documentation finds that this procedure code is not supported as billed.
- Procedure code 20999 cannot be recommended for reimbursement. Review of the submitted medical documentation finds that this procedure code is not supported as billed.
- Procedure code 94762 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.

4. The total allowable reimbursement for the services in dispute is $11,077.85. This amount less the amount previously paid by the insurance carrier of $6,464.24 leaves an amount due to the requestor of $4,613.61. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,613.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,613.61, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.